Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 14, 2023

Inspection Number: 2023-1568-0004

Inspection Type:
Critical Incident

Licensee: City of Hamilton

Long Term Care Home and City: Macassa Lodge, Hamilton

Lead Inspector	**Inspector Digital Signature**
Diane Schilling (000736)	Diane Schilling Digitally signed by Diane Schilling Date: 2024.01.03 11:30:13 -05'00'

Additional Inspector(s)
Josee Snelgrove (674)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-8 and December 12, 2023

The following intake(s) were inspected:

- Intake: #00095767 – related to an improper transfer of a resident
- Intake: #00097728 – related to COVID Outbreak
- Intake: #00099810 – related to alleged abuse
- Intake: #00100684 – related to falls prevention and management
- The following intakes were completed in this inspection: Intake #00087273, Intake: #00094763, Intake: #00089651, Intake: #00090956, Intake: #00094763, Intake: #00096178 and Intake: #00097163 were related to falls

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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from sexual abuse by another resident.

The legislation defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member
(O. Reg. 246/22 s. 2).

Rationale and Summary

A staff member entered a congregate setting and observed a resident display an inappropriate behaviour towards another resident. No communication of consent was exchanged.

At the time of this incident support was not in place as required to protect other

residents from this behaviour.

When the home failed to ensure the resident had interventions in place, as required, another resident was impacted.

Sources: Clinical records, interviews with staff members
[000736]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure safe positioning techniques were used when a resident was transferred.

Rationale and Summary
A resident required total assistance from two staff for transferring using a mechanical lift.

Two staff members assisted the resident with the transfer. During the transfer the resident sustained an injury.

The home's Mechanical Left Policy stated that the staff are to ensure that all pieces of the transfer devices are in place prior to the transfer.

The staff member reported that all pieces were not in place for the transfer device as required by the policy.

Failure to use safe transferring techniques caused injury to the resident.

Sources: Interviews with staff members, Critical Incident Report, resident clinical records.
[674]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including implementing interventions.

Rationale and Summary
A resident required monitoring.

A staff member witnessed a resident display inappropriate behaviour towards another resident. They stated that no other staff were present.

The nurse manager stated the monitoring was delegated to another staff member when they were on break, but no one was monitoring the resident when the incident occurred.

When monitoring was not implemented for a resident as required, residents were at risk of harmful interactions occurring.

Sources: clinical records, interviews with staff members
[000736]